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Supreme Court of the United States

October Term, 1995

REV. PAUL SCHENCK and
DWIGHT SAUNDERS,

Petitioners,

v.

PRO-CHOICE NETWORK OF WESTERN NEW YORK, et al.

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF FEMINIST MAJORITY FOUNDATION, et al., AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICUS CURIAE

The Feminist Majority Foundation ("Foundation") is a non-profit organization with offices in Arlington, Virginia and Los Angeles, California. The Foundation is dedicated to eliminating sex discrimination and to the promotion of equality, women's rights, and safe access to abortion and birth control. The Foundation actively pursues legal protection for reproductive health services, and provided legal counsel for Respondent Women's Health Center in *Madsen v. Women's Health Center, Inc.*, 114 S.Ct. 2516 (1994).

The Foundation runs the largest clinic defense project in the nation, and has been active in defending the clinics in western New York that are the subject of this appeal. Since 1989, the Foundation's National Clinic Access Project has mobilized and trained more than 40,000 volunteers in more than 40 cities in 22 states to assist clinics targeted by anti-abortion groups. As part of this Project, the Foundation coordinated the response to major blockades that were part of the pattern of illegal obstructions addressed by the injunction at issue in this case. In this capacity, staff, volunteers, and supporters of the Foundation witnessed first-hand the violence directed against clinics in Buffalo, the clinic workers, and the women who seek the clinics' services.

SUMMARY OF ARGUMENT

Most of the legal issues posed by Petitioners in this appeal have been explicitly resolved by this Court in its *Madsen* decision. In particular, *Madsen* resolved any lingering doubt that the First Amendment and the prior

restraint doctrine permit the sort of injunction issued in this case. *Madsen* held unequivocally that an injunction is not a content-based regulation of speech merely because the injunction is directed against a particular group whose members persistently obstruct access to abortion clinics, or repeatedly harass clinic patients and staff.

Thus, under the appropriate *Madsen* standard, the only questions in this case are (1) whether the injunction is supported by one or more significant interests, and (2) whether the injunction burdens more speech than is necessary to serve that interest. Both of these questions must be answered in favor of the injunction.

The interests supporting the injunction in this case are identical to the interests recognized as significant by this Court in its *Madsen* opinion. In this case, as in *Madsen*, the injunction serves to protect women's access to lawful and necessary medical care, promotes public safety and order, ensures the unobstructed ingress to and egress from clinics, protects private property rights, and protects the medical privacy of patients at the clinics. The facts regarding the obstruction and harassment of clinics, clinic staff, and patients in western New York are indistinguishable in kind or degree from the facts that this Court recognized in support of the injunction in *Madsen*. Additionally, Amicus Feminist Majority Foundation has assembled a large body of empirical evidence from a comprehensive survey of clinics around the country indicating the importance of injunctions such as the one in this case in preventing the persistent violence directed at clinics by anti-abortion activists.

The injunction provisions challenged by Petitioners also easily satisfy the *Madsen* requirement that they burden no more speech than necessary to accomplish these interests. The 15-foot buffer zone this injunction creates around clinic entrances and driveways is necessary to preserve access to the clinics, and is actually more protective of speech than the injunction upheld by this Court in *Madsen*, which created a 36-foot buffer zone that forced protesters to move across the street from the clinic. Likewise, the provision of the present injunction that creates a 15-foot buffer zone around individuals approaching or leaving a clinic, and which requires protesters to cease and desist "counseling" persons who express a desire to be left alone, is necessary to prevent the systematic harassment and coercion of patients that the District Court found to exist before the injunction was issued, and also to protect medical safety and privacy.

ARGUMENT

I. *MADSEN V. WOMEN'S HEALTH CENTER* PROVIDES THE PROPER STANDARD IN THIS CASE

In *Madsen v. Women's Health Center*, this Court articulated the First Amendment standard applicable to content-neutral injunctions that affect speech and expressive actions. In such cases, the Court held that the traditional time, place, and manner test must be replaced by a "somewhat more stringent application of general First Amendment principles." *Madsen*, 114 S.Ct. at 2524. Under the revised *Madsen* standard, "We must ask . . . whether the challenged provisions of the injunction burden no more speech than necessary to serve a significant governmental interest." *Madsen*, 114 S.Ct. at 2525.

Petitioners argue that the injunction in this case should be judged under a strict prior restraint standard

rather than what they characterize as the "exceptional" *Madsen* standard. *See* Pet. Br. at 23.[1] Indeed, Petitioners contend that the application of the *Madsen* standard is essentially limited to the "highly unusual factual circumstances at the abortion facility in Melbourne, Florida." Pet. Br. at 26.

This argument directly contradicts explicit statements in the *Madsen* opinion itself. In *Madsen*, the Court specifically considered and rejected a prior restraint analysis for reasons that are directly applicable to the injunction in this case. *See Madsen*, 114 S.Ct. at 2524 n.2. In *Madsen*, as in this case, the protesters potentially affected by the trial court's order could express their opinions in many different ways, so long as they did not do so within the narrow buffer zone defined by the injunction. *Id.* Likewise, in *Madsen*, as here, the injunction was not issued because of the content of Petitioners speech, but rather because of the Petitioners' obstructive conduct. *Id.* Thus, as the Court concluded in *Madsen*, "[n]ot all injunctions which may incidentally affect expression . . . are 'prior restraints'." *Id.* As discussed in the next section of this brief, there are no significant differences between the type or magnitude of conduct in this case and the conduct in *Madsen*.

Therefore, *Madsen* provides the proper standard for assessing whether the injunction in this case passes muster under the First Amendment. Accordingly, the first question in this case is whether the injunction issued by the District Court served a significant governmental interest, and the second question is whether the injunction

1. Petitioners' Brief will be referred to as "Pet. Br." throughout this brief.

burdened no more speech than necessary to serve that interest.

II. THE RESPONDENTS' INTERESTS IN AVOIDING VIOLENCE, HARASSMENT, AND OBSTRUCTION OF THEIR FACILITIES ARE IDENTICAL TO THE INTERESTS SUPPORTING THE INJUNCTION UPHELD BY THIS COURT IN *MADSEN*

In their response to the Second Circuit's opinion in this case, the Petitioners inaccurately minimize the facts relating to attacks on clinics in western New York that led to the imposition of the injunction by the District Court. Petitioners also misstate the scope and application of the *Madsen* holding. Petitioners argue that the Second Circuit's *in banc* opinion in this case neglected "two crucial factors in the *Madsen* analysis: first, the need for initial resort to a narrower, nonspeech-restrictive injunction before imposing broader restrictions; and second, the need for a showing of pervasive lawbreaking to which the broader injunction provides a remedial measure." Pet. Br. at 27. Even if this narrow phrasing accurately reflects the *Madsen* holding, the facts in this case easily satisfy the standard.

In this case, the District Court's preliminary injunction was preceded by two years of blockades and other attacks on clinics in the Buffalo area. Also, before entering the preliminary injunction challenged in this case, the District Court *did* resort initially to a narrower order in the form of a Temporary Restraining Order. Unlike the preliminary injunction, the TRO did not contain provisions imposing 15-foot buffer zones around clinic entrances, driveways, parking lots, or vehicles coming to

or leaving from clinics. *Compare Pro-Choice Network of Western New York v. Schenck*, 67 F.3d 377, 382 n.1 (2d Cir. 1995)(quoting relevant portion of TRO) *with id.* at 393 (quoting relevant portion of preliminary injunction). Multiple violations of the District Court's TRO would certainly constitute "a showing of pervasive lawbreaking to which the broader injunction provides a remedial measure." *See Pro-Choice Network of Western New York v. Project Rescue Western New York*, 799 F.Supp. 1417, 1423 (1992)(detailing contempt motions brought against various protesters for violating District Court's TRO). Thus, the facts in this case satisfy even the Petitioners' narrow articulation of the *Madsen* standard.

Putting aside the strong evidence in this case, Petitioners' characterization of the *Madsen* factors is flawed. With regard to the first factor cited by Petitioners, nothing in the *Madsen* decision requires a trial court confronting ongoing obstructions of medical facilities to issue an ineffective injunction before it can issue an effective one. The fact that a prior injunction in *Madsen* failed to solve the problems posed by obstructive protests outside the Melbourne clinic was relevant to the First Amendment analysis only because the facts surrounding the violations of the prior injunction contributed to the trial court's determination that "allowing the petitioners to remain on the clinic's sidewalk and driveway was not a viable option." *Madsen*, 114 S.Ct. at 2527. Certainly, as this Court noted in *Madsen*, the failure of a previous injunction "may be taken into consideration in evaluating the constitutionality of the broader order," *id.*, but such an order (if it exists) is simply part of

the entire factual context that any trial court facing similar circumstances must face. Facts other than the violation of a previous injunction can also contribute to a trial court's conclusions about the viability of effective injunction provisions, as they obviously did in the present case.

This Court's discussion of the factual predicates to the *Madsen* injunction indicates that even if there had been no prior injunction in *Madsen*, the facts of that case would justify injunction provisions such as the buffer zone surrounding the clinic. The conduct identified by the trial court in *Madsen*, such as the blocking of ingress to and egress from buildings and the harassment of patients going to and from clinics, would in themselves satisfy the significant state interest requirement of the *Madsen* standard. Cases of this sort are always highly fact-specific, and as the Court pointed out in *Madsen*, "some deference must be given to the [trial] court's familiarity with the facts and the background of the dispute between the parties even under our heightened review." *Madsen*, 114 S.Ct. at 2527.

The second "crucial factor" cited by Petitioners as part of the *Madsen* standard also pertains to the issue of whether the injunction is supported by a significant governmental interest. In this respect, Petitioners' assertion of "the need for a showing of pervasive lawbreaking," Pet. Br. at 27, fails to acknowledge the breadth of interests that a trial court may consider in cases such as these. While outright "lawbreaking" may be one legitimate target of a content-neutral injunction, an injunction may also regulate otherwise lawful activity if that activity occurs in an inappropriate setting, at inappropriate times, or in a manner that makes other lawful conduct impossible. The notion that lawful activities may be regulated in this

way is not a novel concept. Similar considerations have long been a part of First Amendment time, place, and manner jurisprudence. In those cases, as here, "[t]he crucial question is whether the manner of expression is basically compatible with the normal activity of a particular place at a particular time." *Grayned v. Rockford*, 408 U.S. 104, 116 (1972).

A recognition of the judicial responsibility to balance competing interests is at the core of the *Madsen* decision. In *Madsen*, this Court held that five significant interests were served by the provisions of the injunction upheld in that case. Drawing on the factual findings of the lower courts, this Court noted that the *Madsen* injunction protected "a woman's freedom to seek lawful medical or counseling services in conjunction with her pregnancy," *Madsen*, 114 S.Ct. at 2526, ensured "the public safety and order," *id.*, promoted "the free flow of traffic on public streets and sidewalks," *id.*, protected private property rights, *id.*, and protected "medical privacy," *id.*, an interest akin to the residential privacy interest acknowledged in previous cases such as *Frisby v. Schultz*, 487 U.S. 474 (1988). According to this Court, "the combination of these governmental interests is quite sufficient to justify an appropriately tailored injunction to protect them." *Madsen*, 114 S.Ct. at 2526.

Petitioners attempt to distinguish this case from *Madsen* by arguing that the *Madsen* holding depended on "rather extraordinary factual circumstances." However, the background to the protests in Buffalo indicates that the circumstances of this case presented to the District Court precisely the same "extraordinary factual circumstances" found in *Madsen*. As in *Madsen*, the trial judge in this case concluded that this injunction provided the narrowest

effective response to an ongoing pattern of aggressive and intentionally obstructive behavior directed at the clinics in Buffalo.

A review of the District Court's opinion in this case reveals findings very similar in nature to those supporting the *Madsen* injunction. With regard to the interest in protecting access to clinics, the District Court found that Respondent clinics have "on numerous occasions" been victims of blockades, during which "demonstrators trespass on the clinic property and sit or lay in the entrances of the clinic in an attempt to block access to and egress from the clinic." *Pro-Choice Network*, 799 F.Supp. at 1424. These tactics often achieved their objective, as the District Court found that "[o]n many of those occasions, the operation of the targeted facility was effectively stopped or significantly hampered." *Id.* The District Court found that demonstrators also constructively blockaded the clinics by "frequently and routinely congregat[ing] in or near the driveway entrances to the facility parking lots in order to impede and obstruct access to the facilities." *Id.* According to the evidence introduced in the District Court, this behavior had caused "stress and sometimes even physical injury to the patients, patient escorts and medical staff, and disrupt[ed] the atmosphere necessary for rendering safe and efficacious health care." *Id.*

With regard to the interest in preserving public safety and order, the District Court found that "[m]any of the 'sidewalk counselors' and other defendants have been arrested on more than one occasion for harassment, yet persist in harassing and intimidating patients, patient escorts and medical staff." *Id.* at 1425. With regard to the traffic control interest, the District Court found that the

demonstrators' activities "intimidates and impedes the drivers of cars seeking access to the parking lots of the facilities and creates a danger both to the occupants of the cars and the demonstrators themselves." *Id.* at 1424. Finally, with regard to the interest in preserving medical privacy, the District Court found that "sidewalk counselors" frequently used video cameras "as offensive weapons to harass and intimidate patients," who "are often terrified at the prospect of anyone, especially family members, finding out that they are having an abortion." *Id.* at 1426.[2] Unfortunately, the ugly scenario that generated the *Madsen* case is not at all "extraordinary"; it was quite accurately replicated in Buffalo.

2. Petitioners' incorrectly assert that "[a] clear majority of the *in banc* Second Circuit forthrightly agreed that this case does not present the record of lawlessness that this Court faced in *Madsen*." Pet. Br. at 45. Petitioners cite Judge Winter's concurring opinion and Judge Meskill's dissenting opinion as support for this statement. *Id.* However, Petitioners fail to cite the clear statement in the Second Circuit's majority opinion--which was joined by nine of the fifteen judges hearing the *in banc* appeal--that "We are not convinced by the dissent's recitation of distinctions between the record in the instant case and in *Madsen*." *Pro-Choice Network of Western New York*, 67 F.3d at 388. Petitioners also fail to note the Second Circuit majority's finding that the injunction was supported by an "extensive record documenting Project Rescue's harassment and intimidation of patients, and documenting the effects produced by such harassment." *Id.* at 389. The District Court's findings cited in the text accompanying this footnote indicates that the District Court was faced with precisely the same types of conduct that the state trial court faced in *Madsen*.

III. THE "SPRING OF LIFE" DEMONSTRATIONS OF 1992 REINFORCE THE DISTRICT COURT'S FINDINGS CONCERNING THE THREATS TO CLINICS IN BUFFALO

The facts cited by the District Court to justify issuing the injunction were not isolated incidents. Rather, these incidents were part of a longstanding pattern of attacks on clinics in Buffalo and western New York. For example, as the District Court found, there was extensive evidence that clinics were subject to blockades on numerous occasions prior to the issuance of the injunction. *Pro-Choice Network*, 799 F.Supp. at 1424. Also, clinic patients and staff were routinely harassed and intimidated. *Id.* at 1424-25. Another manifestation of this pattern of attacks was the so-called "Spring of Life" protests, which commenced in April, 1992. Although the Court of Appeals did not consider the facts surrounding the "Spring of Life" demonstrations, *see Pro-Choice Network*, 67 F.3d at 386 n.3, Amicus Feminist Majority Foundation believes that these demonstrations further illustrate the atmosphere of violence and intimidation that led the District Court to grant the preliminary injunction. The "Spring of Life" demonstrations were part of the larger, systematic attack on the provision of reproductive health care in Buffalo, which provided the impetus for the injunction challenged in this case. Thus, the incidents in the "Spring of Life" demonstrations are relevant to the Court's consideration of these issues.

The "Spring of Life" campaign was an outgrowth of a concentrated series of blockades directed at clinics in Wichita, Kansas during the summer of 1991. The Wichita campaign lasted 46 days and led to 2,600 arrests.

See Catherine S. Manegold, *Protesters Set for Collision on Abortion*, N.Y. Times, April 20, 1992, at B1. The organizers of the Wichita protests next targeted Buffalo and the surrounding western New York area, calling for a two-week series of protests to begin on April 20, 1992. *Id.* Amicus Feminist Majority Foundation's National Clinic Access Project coordinated the response to these planned protests in the Buffalo area, to prevent a repeat of the Wichita experience. Starting eight weeks before the "Spring of Life" action began, six organizers from the Foundation began working with clinic directors, law enforcement, and pro-choice groups to recruit and train volunteers to counteract threatened blockades. The organizers also worked with local attorneys on legal strategies to counteract the protests. The injunction at issue in this case was the single most significant component of the legal response to the protests.

Blockades held in conjunction with the "Spring of Life" demonstrations attracted hundreds of anti-abortion protesters. *See id.* These blockades occasionally turned violent, and police arrested 597 demonstrators during the period from April 20-May 2, 1992. Michael Beebe, *Arrests Profiled*, The Buffalo News, May 27, 1992, at B1. On several occasions, organizers of the "Spring of Life" blocked access to clinics by having large numbers of protesters sit down in public streets. Police were forced to arrest almost 200 protesters for engaging in this tactic outside Respondent Dr. Shalom Press's clinic. According to one press account of this incident, "As police moved protesters to a nearby school bus, other pro-life supporters took their place in the road. By noon, police had filled six buses and were taking protesters to a temporary police station." Tom Ernst & Phil Fairbanks, *Police Arrest Pro-*

Lifers at Amherst Site, The Buffalo News, April 22, 1992, at A1. Respondent Buffalo GYN Womenservices encountered similar tactics when a large group of protesters sat down in the clinic driveway to block vehicular access to the clinic. This incident led to 71 arrests. Gene Warner, Juan Forero & Phil Fairbanks, *71 Pro-Lifers Arrested at City Clinic*, The Buffalo News, April 24, 1992, at A1. At yet a third location, protesters blocked traffic in front of a doctor's office before retreating in the face of police warnings. Gene Warner, Jane Kwiatkowski & Michael Beebe, *Abortion Protesters Block Linwood*, The Buffalo News, April 27, 1992, at C1.

In addition to blocking roads and clinic entrances, "Spring of Life" protesters actually stormed the premises at Buffalo GYN Womenservices in an apparent effort to shut down the provision of medical services altogether. Jane Kwiatkowski & Michael Levy, *71 Arrested In Purported End to Protests: Attempt to Rush Clinic Results in Most Seizures*, The Buffalo News, May 3, 1992, at B1. In this incident, as in many others, the protesters' actions were highly organized and well-coordinated--so much so that the protesters often would outflank the police. When the protesters stormed the Womenservices clinic, for example, the initial police presence was insufficient to protect the clinic, and additional forces had to be ordered in as reinforcements. *Id.* A similar attack took place outside a 13-story medical complex, which contained a clinic on its fifth floor, among many other types of medical offices. Dan Herbeck, Jane Kwiatkowski & Michael Beebe, *5 Leaders of Protest Face Arrest*, The Buffalo News, April 28, 1992, at A1. At this blockade, protesters physically attacked clinic supporters, climbed over snow-fences

erected to prevent trespassing, and crossed police lines in an attempt to shut down the clinic. *Id.* at A4.

These incidents, like the blockades that occurred prior to the issuance of the preliminary injunction, demonstrate that the behavior of anti-abortion protesters in Buffalo was far removed from the "silent witness[ing], . . . polite offers of information, . . . urgent entreaties, . . . pointed criticisms, [and] emotional exclamations" described by Petitioners. Pet. Br. at 24. The behavior here was also far worse than "some picketers and counselors . . . occasionally fail[ing] to say just the right thing in just the right way." Pet. Br. at 21. If the evidence before the District Court had reflected nothing more than the forceful but benign expression of opinion, then the injunction would be subject to challenge on First Amendment grounds. In this case, however, the District Court had abundant evidence that protesters had crossed the line from legitimate speech and were engaged in large-scale intimidation, harassment, and obstruction of clinic personnel and clinic patients. The injunction in this case thus was an indispensable and constitutional response to attacks on Buffalo-area clinics, in light of the longstanding rule that "[v]iolence or other types of potentially expressive activities that produce special harms distinct from their communicative impact . . . are entitled to no constitutional protection." *Roberts v. United States Jaycees*, 468 U.S. 609, 628 (1984). *See also Cameron v. Johnson*, 390 U.S. 611, 615-17 (1968)(rejecting First Amendment challenge to law prohibiting obstruction of courthouse).

IV. EMPIRICAL RESEARCH CONCERNING CLINIC VIOLENCE NATIONWIDE SUPPORTS THE DISTRICT COURT'S ISSUANCE OF THE INJUNCTION IN THIS CASE

For the last three years, Amicus Feminist Majority Foundation has conducted a comprehensive survey of violence directed at clinics nationwide.[3] The results of these surveys provide substantial empirical support to the conclusions of the District Court in this case. The information discussed in this section is not intended to suggest that courts may issue injunctions based on generalized national findings. Rather, the survey results provide support for the efficacy and necessity of the District Court's response to a problem that has also been encountered in other jurisdictions. The survey results also indicate that trial courts remain reluctant to issue injunctions protecting clinics in the absence of substantial evidence of the sort that was introduced in the District Court in this case.

Four specific conclusions can be drawn from these surveys that are relevant to this case: First, the surveys

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3. The survey results discussed in this section of the Foundation Amicus brief are drawn from this 1995 Report. Feminist Majority Foundation, 1995 Clinic Violence Survey Report. The 1995 survey was mailed to 902 clinics in the United States and American Samoa in September, 1995, and follow-up calls were made in September and October, 1995. Surveys were completed by 310 clinics. "Data were analyzed using SPSS-X (Statistical Package for the Social Sciences) uni-variate and bi-variate statistical techniques." *Id.* at 1.

indicate that violence and threats of violence continue to plague reproductive health clinics throughout the country. Second, the violence and threats reported by clinics significantly impacts the effectiveness of clinic operations, especially by making it difficult for clinics to hire and retain staff. Third, violence against clinics can be substantially reduced through effective law enforcement action, including the enforcement of protective injunctions. Fourth, injunctions of the sort issued in this case are not routinely granted. Although many clinics have obtained protective injunctions, most clinics that sought such injunctions during the last year were denied relief.

The first conclusion drawn from the Foundation's survey indicates that violence against clinics is a persistent problem nationwide. In 1995, "38.6 percent of clinics experienced one or more of the most severe forms of clinic violence," including "death threats, stalking, bomb threats and bombings, chemical attacks, blockades, invasions, and arson threats and arson attacks." *1995 Clinic Violence Survey Report*, at 3. More than 15 percent of the clinics experienced two or more different types of severe violence. *Id.* at 4. If vandalism, home picketing, and gunfire are also included, more than half of the clinics surveyed--a total of 55.8 percent--experienced some violence during 1995.

Even more disturbing is the breakdown of violent activities directed at clinic workers. Almost one in five clinics (17.1 percent) reported receiving death threats against its personnel, and more than one in ten (10.6 percent) reported that clinic staff had been stalked. The authors of the Survey conclude that the shift toward individualized threats to workers, rather than broad attacks on clinics, is in part attributable to the imposition of *Madsen*-

style injunctions and clinic buffer zones. *1995 Clinic Violence Survey Report*, at 6. This conclusion argues in favor of injunction provisions such as the buffer zone around individuals imposed by the District Court in this case, which will protect threatened clinic staff and patients, in addition to the protection of facilities offered by injunction provisions such as the fixed buffer zone upheld in *Madsen* (and, in a more restricted form, also used in this case). This type of injunction provision is no broader than the injunction upheld by this Court in *Madsen*; it simply responds to a somewhat different (but equally well-documented) problem than the lower court faced in that earlier case.

The second major conclusion drawn from the Foundation's 1995 Survey pertains to the specific administrative consequences of violence on the clinics surveyed. As a result of the targeting of individual workers by anti-abortion activists, clinics have long had a difficult time hiring and retaining staff, including key medical personnel such as doctors and nurses. "In 1995, 9% of clinics reported that staff members had quit as a result of anti-abortion violence and harassment." *1995 Clinic Violence Survey Report*, at 7. Not surprisingly, the clinics that were subject to the greatest incidence of violent attacks suffered the greatest staff attrition. "Of the clinics experiencing high levels of violence, 13.6% said staff members had resigned, compared with 9.3% of clinics reporting moderate violence and 7.3% of clinics reporting no violence." *Id.* The judicial interest in "protect[ing] a woman's freedom to seek lawful medical or counseling services in conjunction with her pregnancy," *Madsen*, 114 S.Ct. at 2526, necessarily encompasses the interest in protecting the personnel who perform these medical and

counseling services. Once again, although some provisions of the injunction in this case are specifically designed to protect clinic patients and personnel as opposed to clinic facilities, the underlying interests justifying the injunction here are the same as those endorsed by this Court in *Madsen*.

The third conclusion drawn from the Foundation's 1995 Survey is that effective law enforcement action correlates strongly with the diminution of violence against clinics. "Only 11%of clinics reporting excellent local law enforcement experienced high levels of violence, compared with 33.3% of clinics who reported poor law enforcement response." *1995 Clinic Violence Survey Report*, at 10. Similar patterns were evident with regard to state law enforcement response. Of particular note regarding the issues in the present appeal, death threats and stalking--two examples of violence that are likely to be controlled by the injunction provisions being challenged by Petitioners here--consistently correspond to effective law enforcement at every level. *Id.*

Despite the clear correlation between law enforcement effectiveness and the control of violence against clinics, two problems with law enforcement response to clinic violence are evident from the Survey. First, despite increased police efforts to work with clinics in response to violent activities of protesters, very few of the violent episodes reported by clinics led to arrests. "Only 13.8% of clinics reported arrests as a result of violence at clinics." *Id.* at 11. Second, primary protection of clinics continues to be left to local officials and federal and state judges, rather than federal law enforcement officials, despite the enactment in 1994 of the federal Freedom of Access to Clinics Act (FACE), 18 U.S.C. §248 (1996),

which makes anti-clinic violence a federal crime. The Survey found that among the clinics reporting FACE violations to the federal authorities, only 14.5 percent of the complaints were formally investigated, and the parties involved were officially interviewed only 12.9 percent of the time. *Id.* at 8. Only 8.1 percent of the complaints led to the filing of criminal proceedings. *Id.* Over half of the clinics filing FACE complaints (54.8 percent) were told that their claims should be handled locally. *Id.* This low level of criminal prosecutions by federal and local officials indicates the continued importance of precise and highly-focussed local remedies, such as injunctions and contempt actions. Existing remedies under broad state and federal criminal statutes simply have not provided adequate relief to stem the violence that many clinics in the United States continue to confront daily.

These problems are evident in this case. The District Court found that "[l]ocal law enforcement has been unable to respond effectively to plaintiffs' complaints about 'pro-life' demonstrators harassing patients and blocking access to the clinics." *Pro-Choice Network*, 799 F.Supp. at 1426. The District Court also found that "[e]ven when police arrest a 'pro-life' demonstrator for harassing a patient, successful prosecution is often difficult because the patient is reluctant to testify or cooperate out of fear that her identity might be made public. Furthermore, the record shows that arrest and conviction pursuant to local laws has not deterred defendants from repeatedly engaging in their illegal pattern of activity." *Id.* Local law enforcement of ordinary criminal statutes has been woefully inadequate to protect the staff and patients of clinics in western New York. As the District Court concluded, many of these problems can be

overcome by the imposition of an injunction, enforceable through contempt actions, including civil contempt actions brought by the plaintiffs.

The final conclusion that can be drawn from the Foundation's Survey serves to assuage Petitioners' concern that unless this Court's *Madsen* decision is limited to its facts, "it would follow from *Madsen* that courts could issue speech-restrictive injunctions virtually upon demand." Pet. Br. at 28. The results of the Foundation Survey demonstrates that this is certainly not how *Madsen* has been interpreted and applied by the lower courts that have been approached by clinics requesting injunctions. Although more than half of the clinics reported violence, only 35.5 percent of the clinics surveyed by the Foundation are currently covered by an injunction or buffer zone. *1995 Clinic Violence Survey Report*, at 11. Injunctions are not routinely requested by all clinics, nor do the courts automatically issue the injunctions that are requested. In 1995, only 15.2 percent of clinics requested civil legal relief (3.2 percent of these cases involved requests for temporary injunctions, 5.8 percent were requests for permanent injunctions, and 4.2 percent were requests for restraining orders). *Id.* Most of these requests for legal relief were denied. "Only 46.8% of clinics who sought legal remedies actually obtained the desired protection." *Id.* Only in the small category of requests for permanent injunctions--issued after full fact-finding by the trial courts--were most of the clinics (72.2 percent, or 13 of 18 clinics) successful in obtaining relief. *Id.* Thus, the survey results indicate that trial courts continue to review injunction requests rigorously and skeptically; there is no evidence whatsoever to support Petitioners' implication that *Madsen* is being used by trial courts to issue rubber-

stamp injunctions against anti-abortion protesters "virtually upon demand."

V. THE INJUNCTION IN THIS CASE DOES NOT BURDEN MORE SPEECH THAN IS NECESSARY TO PROTECT THE CLINICS

The final issue in this case is whether the injunction entered by the District Court below burdens more speech than necessary to protect the various significant interests discussed in the previous sections of this brief. Petitioners find two provisions of the injunction particularly objectionable: First, they object to the buffer zone provision, which prohibits demonstrations within fifteen feet of clinic entrances and driveways, or within fifteen feet of persons or vehicles coming to or going from abortion facilities, *Pro-Choice Network*, 67 F.3d at 393; second, they object to the "cease and desist" provision, which permits up to two "sidewalk counselors" to enter the 15-foot buffer zone surrounding persons entering or leaving a clinic, but requires the counselors to "cease and desist from such counseling," and retreat from the zone if the person being approached "indicates, either verbally or non-verbally, that they do not wish to be counseled." *Id.* at 391.

Petitioners' argument that these provisions burden too much speech misconstrues both the injunction and this Court's holding in *Madsen*. Not only are these provisions actually narrower in key respects than the injunction provisions approved by this Court in *Madsen*, each of these provisions is well within the scope of equitable discretion provided to the lower courts by the *Madsen* decision.

Thus, Petitioners' challenge to the injunction must be rejected.

As a prelude to discussing the differences between the *Madsen* injunction and the injunction in this case, it is important to note the important ways in which the injunctions are the same. In *Madsen*, this Court upheld an injunction provision imposing a 36-foot buffer zone to the south and east of a clinic in Melbourne, Florida. In three key respects, the 36-foot buffer provision in *Madsen* is indistinguishable from the 15-foot buffer provision here. First, both provisions were devised as "a means of protecting unfettered ingress to and egress from the clinic." *Madsen*, 114 S.Ct. at 2527. *See Pro-Choice Network*, 799 F.Supp. at 1433 ("paragraph (b) of the preliminary injunction secures unfettered access to the clinics. . . ."). Second, both provisions were entered only after the trial courts "found that [protesters] repeatedly had interfered with the free access of patients and staff." *Madsen*, 114 S.Ct. at 2526. *See Pro-Choice Network*, 799 F.Supp. at 1424-27 (detailing District Court's findings regarding systematic blockading of clinics and harassment of clinic patients and staff). Third, both provisions rely upon "a distinction between the type of focused picketing banned from the buffer zone and the type of generally disseminated communication that cannot be completely banned in public places, such as handbilling and solicitation." *Madsen*, 114 S.Ct. at 2527. *See Pro-Choice Network*, 799 F.Supp. at 1436 ("the 'cease and desist' provision shields only unwilling listeners from defendants' message"); *id.* at 1437 ("[protesters] can still picket, carry signs, pray, sing or chant in full view of people going into the clinics or just passing by.").

To the extent that the provisions of the injunction in this case are different than those in the *Madsen* injunction, the provisions challenged here are actually more speech-protective than the 36-foot buffer zone in that case. Most obviously, in this case the District Court imposed only a 15-foot buffer zone around the entrances and driveways of clinics. This zone is less than half as large as the 36-foot zone upheld in *Madsen*. This is important because unlike the provision upheld in *Madsen*, the buffer zone in this case does not have the effect of pushing demonstrators to the opposite side of the street from the clinic. Under the injunction upheld in this case, demonstrators can remain in close proximity to the clinic entrances, so long as they do not block those entrances. Thus, the demonstrators' placards and signs can be seen easily by those coming into a clinic, and demonstrators will have no trouble communicating verbally with those approaching the clinic entrances. *See Pro-Choice Network*, 799 F.Supp. at 1436.

With regard to the "floating" 15-foot buffer zone around persons approaching or leaving the clinics, Petitioners hyperbolically envision a situation in which "picketers, leafletters, and anyone else who could be characterized as 'demonstrating' must flee from approaching pedestrians on pain of contempt." Pet. Br. at 49. Petitioners paint a picture of being "bulldozed" off the sidewalks by patients going to or coming from clinics: "If a placard-carrying individual should fail to pay close attention in all directions, a 'speech-free bulldozer' may run him over before he has time to conceal his sign." *Id.* Of course, none of these speculations are based on any evidence in the history of this case. No one has ever been held in contempt for coming too close to another

pedestrian while innocently trying to avoid contact with a person en route to a clinic. The reality of the protesters' behavior is quite different, and was noted by the District Court in its opinion issuing the preliminary injunction: "There was testimony adduced at the hearings that defendants have attempted to circumvent [a similar provision in the TRO] by using a 'relay' system, *i.e.*, once the targeted person rejects the counseling of a particular 'sidewalk counselor,' another one steps forward and continues counseling. This 'relay' system obviously violates the spirit, if not the letter, of the Court's TRO." *Pro-Choice Network*, 799 F.Supp. at 1435 n.12. Protesters around clinics in western New York do indeed "pay close attention in all directions," but they do so in order to ambush frightened clinic patients, not to get out of their way.

Evidence such as this points to the necessity of the buffer zone surrounding those going to and from the clinics. In the absence of such a buffer, protesters would have free rein to engage in the very conduct that the District Court found was common among demonstrators outside clinics in the Buffalo area prior to the issuance of the TRO: "During these encounters, 'sidewalk counselors' often become angry and frustrated when patients and patient escorts persist in entering the clinics. The 'counselors' then turn to harassing, badgering, intimidating and yelling at the patients and patient escorts in order to dissuade them from entering." *Id.* at 1425 (footnote omitted). This Court noted in *Madsen* that "face-to-face solicitation presents risks of duress that are an appropriate target of regulation." *Madsen*, 114 S.Ct. at 2529 (quoting *International Society for Krishna Consciousness (ISKCON) v. Lee*, 505 U.S. 672, 684 (1992)). Nothing in *Madsen* or any other First Amendment case provides

protesters the absolute right to engage in aggressive, face-to-face harassment of individuals.

Petitioners repeatedly argue that the buffer zone surrounding individuals entering or leaving a clinic creates a "speech-free zone." *See* Pet. Br. at 44, 45, 46, 47, 48. Although this is an accurate description of the 36-foot buffer zone upheld by this Court in *Madsen* (which contained no exceptions for speech by protesters), it does not accurately characterize the "floating" buffer zone created by the injunction in this case. In this case, the District Court specifically permitted up to two sidewalk counselors to enter the 15-foot buffer zone surrounding individuals, but required such counselors to "cease and desist" their approach if the person approached indicated a desire to be left alone.

Petitioners challenge the "cease and desist" provision by analogizing it to the provision of the *Madsen* injunction prohibiting protesters from approaching persons seeking the services of a clinic within a 300-foot zone around the clinic. This Court struck down that provision on the ground that it prohibited "all uninvited approaches of persons seeking the services of the clinic, regardless of how peaceful the contact may be. . . ." *Madsen*, 114 S.Ct. at 2529. The simple answer to Petitioners' analogy is that the relevant provision in this case does *not* prohibit "all uninvited approaches." In fact, the injunction specifically *permits* such approaches. What the provision *does* prohibit is the forced imposition on a listener of speech that the listener does not want to hear. Petitioners' analogy to *Madsen* is inapt because there is a fundamental difference between an injunction that prohibits someone from "selling" his or her perspective in the marketplace of

ideas, and an injunction that prohibits a speaker from forcing a listener to "buy" the speaker's perspective.

Petitioners' own citations underscore this difference. Petitioners cite Justice Souter's opinion from *ISKCON v. Lee*, in which Justice Souter noted that in the face of an insistent solicitor, "a pedestrian on the street . . . can simply walk away or walk on." *ISKCON v. Lee*, 505 U.S. at 713 (Souter, J., concurring in part and dissenting in part), cited in Pet. Br. at 39. But Petitioners failed to note Justice Souter's reference to the fact that in *ISKCON* "there is here no evidence of any type of coercive conduct, over and above the merely importunate character of the open and public solicitation, that might justify a ban. . . ." *Id.* This case is a good example of the "coercive conduct" that Justice Souter recognized might justify a regulation of face-to-face speech. In this case, the District Court had abundant evidence of coercive abuse of clinic patients by protesters. Petitioners fail to acknowledge the District Court's finding that "counselors" often "turn to harassing, badgering, intimidating, and yelling at the patients and patient escorts in order to dissuade them from entering [the clinics]. They continue to do so even after the patients signal their desire to be left alone." *Pro-Choice Network*, 799 F.Supp. at 1425. The "cease and desist" provision in the injunction was thus narrowly tailored to preserve the right of protesters to approach pedestrians peacefully, while at the same time preserving the right of clinic patients to avoid the kind of harassment and abuse that had become common at the time the injunction was issued.

In sum, each provision of the injunction challenged by Petitioners satisfies the *Madsen* requirement that it burden no more speech than necessary to protect clinic

patients and personnel from harassment and coercion. As the Court of Appeals held, the injunction does no more than preserve the rights of patients and clinic personnel, while leaving intact the protesters' First Amendment right to "approach anyone else to attempt to 'counsel' them, or to hand out leaflets to passersby, or to demonstrate as she sees fit within the bounds of the injunction." *Pro-Choice Network*, 67 F.3d at 391.

CONCLUSION

This Court should affirm the judgment of the Second Circuit Court of Appeals.

Respectfully submitted,

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APPENDIX A

1995 CLINIC VIOLENCE SURVEY REPORT

Conducted by
THE FEMINIST MAJORITY FOUNDATION

1995 CLINIC VIOLENCE SURVEY REPORT
FEMINIST MAJORITY FOUNDATION

METHODOLOGY

For the third consecutive year, the Feminist Majority Foundation conducted a nationwide survey of anti-abortion violence that occurred during the first seven months of 1995. In September of 1995, surveys were mailed to 902 clinics in the United States, and American Samoa. Follow-up phone calls to clinics were made in September and October. Surveys were completed by 310 clinics, producing a response rate of 34%. Data were analyzed using SPSS-X (Statistical Package for the Social Sciences) uni-variate and bi-variate statistical techniques. This annual survey represents one of the most comprehensive studies of anti-abortion violence directed at clinics, patients, and health care workers.

The sample of 310 clinics in the 1995 survey includes facilities in 44 states and American Samoa. (See Appendix A for list of number of clinics per state.) The percentage of clinic practice devoted to abortion ranges from less than 5% to over 75%. Clinics represented in the sample are almost evenly divided among facilities that are non-profit (31%), for-profit (38.1%), and private doctors offices (30%).

Many of these clinics provide a wide range of gynecological and other health care services. The 1995 survey found that 94.8% of clinics provide health services in addition to abortion. Clinics provide birth contol (92.6%), cancer screening

(68.1%), pre-natal care (24.8%), menopause treatment (58.1%), tubal sterilization (29.7%), adoption and referral services (22.3%), infertility treatment (26.8%), PMS Treatment (51.6%), AIDS Testing (60%), reproductive health counseling (83.2%), pregnancy counseling (86.8%), and STD testing and treatment (82.3%).

Clinics that responded to the survey were assured that their individual responses would remain confidential. Clinics are identified by name or state only if the incidents and consequences of the violence are a matter of public record or if the Feminist Majority Foundation was given permission to include the details of the incident in this report.

KEY FINDINGS

- Levels of clinic violence in 1995 declined substantially. In 1995, 38.6% of clinics experienced one or more of the most severe forms of clinic violence, including death threats, stalking, bomb threats and bombings, chemical attacks, blockades, invasions, and arson and arson threats. This rate is down significantly from 51.9% of clinics in 1994 and 50.2% in 1993. The proportion of clinics experiencing one or more types of violence grew to 55.8% when home picketing, vandalism, and gunfire also were tabulated. In 1994, 66.7% of clinics experienced at least one of the twelve types of violence.

- For the first time, in every category of violence, more clinics in 1995 reported decreases than increases in incidents. The smallest net decreases, however, were in reports of death threats and stalking.

- Violence directed at individual physicians and clinic staff members continued at unacceptably high levels. Almost one in five clinics (17.1%) reported death threats in 1995; one in five (20.3%) reported home picketing; and one in ten (10.6%) said clinic staff had been stalked.

- Violence directed at physicians and clinic staff has taken its toll. Clinic staff resignations as a result of anti-abortion violence remained at 1994 levels, with almost one in ten (9%) of clinics having lost clinic staff for this reason. The majority (60.7%) of violence-related staff resignations occurred as a result of the December 30, 1994 murders of clinic workers in Brookline, Massachusetts.

- One in five clinics reported violations of the Freedom of Access to Clinic Entrances Act to federal law enforcement officials, representing an increase from 16.5% in 1995. The majority (54.8%) of clinics reporting FACE violations were directed by federal authorities to seek assistance from local and state laws and law enforcement officials.

- Decreases in clinic violence corresponded with law enforcement response. Local, state, and federal law enforcement officials won higher marks from clinics for their response to anti-abortion violence in the (sic) 1995 than in 1994. The greatest improvement in law enforcement response was seen at the local level, where 34.5% of clinics reported enforcement efforts had "improved."

- Clinic demands for legal remedies from the courts experienced mixed success. In 1995, 15.2% of clinics sought judicial relief from clinic violence, but less than half (46.8%) actually obtained the legal remedy sought. Over one-third (35.5%) of clinics are now protected by a buffer zone or civil injunction.

RESULTS

Anti-Abortion Violence Declines in 1995; One-third of Clinics Still Under Serious Attack

One year after passage of the Freedom of Access to Clinic Entrances Act and a U.S. Supreme Court ruling allowing the creation of "buffer zones" around women's health care clinics,

the level of violence at abortion clinics has declined significantly. However, *over one-third of clinics remained under serious attack by anti-abortion forces during the first seven months of 1995.*

In 1995, 38.6% of clinics experienced one or more of the most severe forms of clinic violence. Types of violence included *death threats, stalking, bomb threats and bombings, chemical attacks, blockades, invasions, and arson threats and arson attacks.* This level of violence represented a drop of 13.3 points from 51.9% of clinics in 1994 and a drop of 11.6 points from 50.2% in 1993. (See Chart 1.)

As Chart 2 shows, 22.3% of clinics in 1995 experienced one type of violence, 10% reported two types, 4.2% were the targets of three types of violence, and .9% experienced four or more types of violence. Chart 2 also compares 1995 levels of violence with 1993 and 1994.

Both the 1995 and 1994 surveys also measured additional types of violence: *vandalism, home picketing, and gunfire.* When these variables are incorporated, *the percentage of clinics that experienced violence in 1995 grows to 55.8%.* In 1994, 66.7% of clinics were the targets of one or more of these ten types of violence.

Collapsing the twelve violence variables into three levels of violence further revealed the decline in intensity of violence between 1995 and 1994. In 1995 14.2% of clinics were heavily targeted experiencing a high level of violence (3 or more types), compared with 22.2% in 1994. In the 1995 survey, 41.6% reported a moderate level of violence (1 or 2 types); 44.5% experienced moderate levels of violence in 1994. In 1995, 44.2% of clinics had not experienced any of these types of violence; one third (33.3%) of clinics in 1994 indicated they had not faced anti-abortion violence.

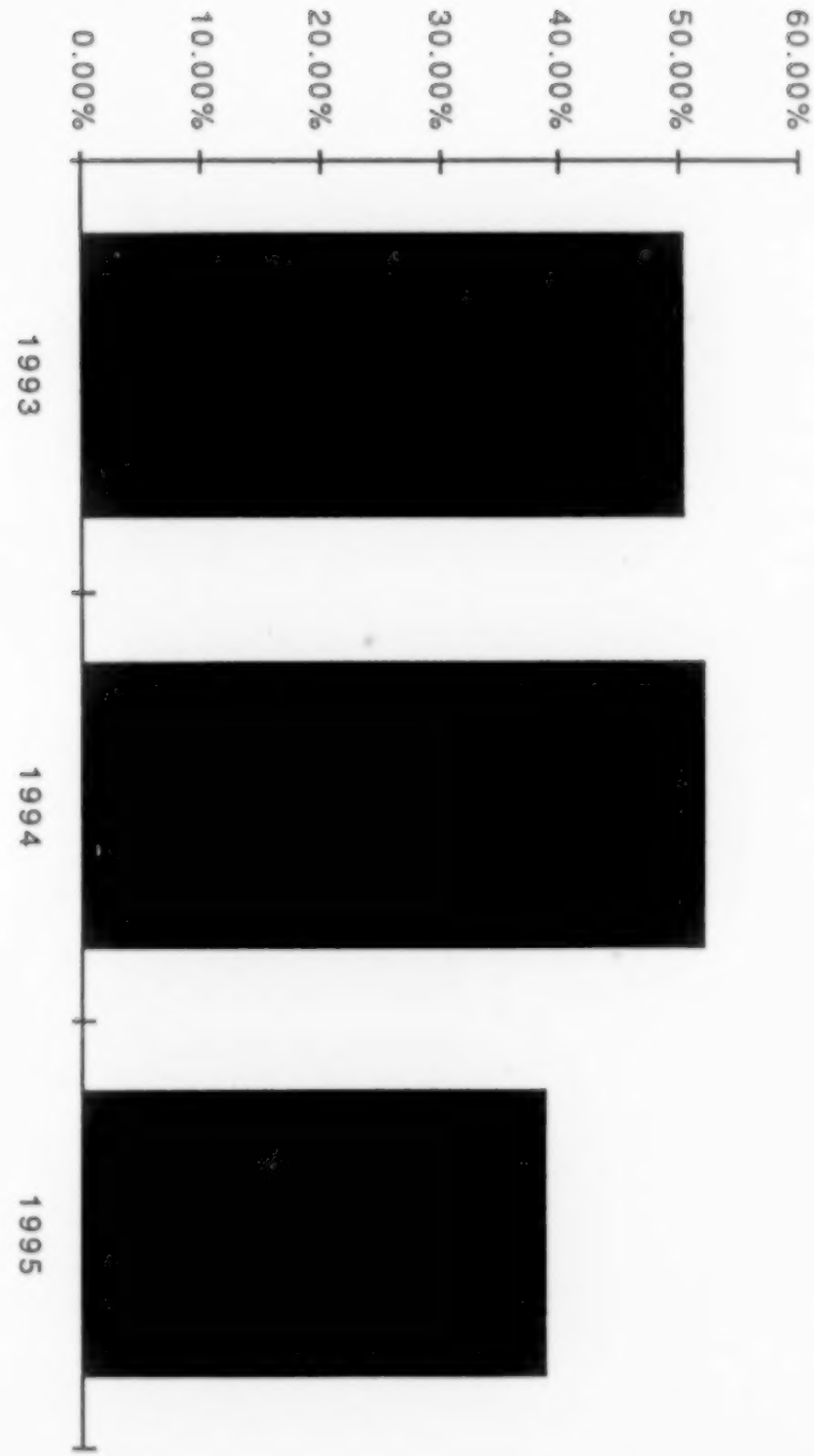
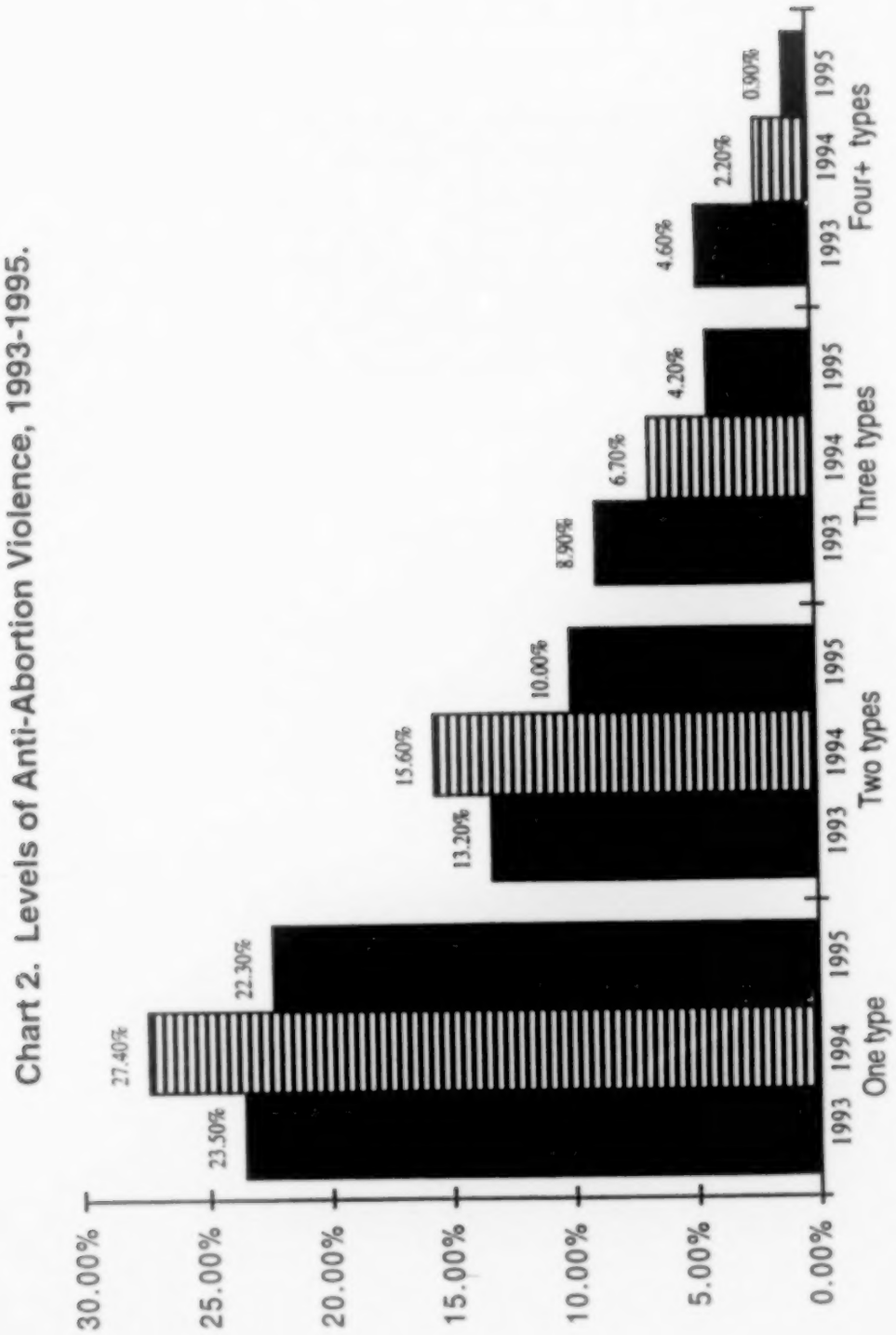


Chart 1. Clinics Experiencing One or More Types of Anti-Abortion Violence, 1993-1995.



Violent acts against clinics and health care workers were nationwide. The survey, however, revealed especially severe anti-abortion violence in Alabama, California, Colorado, Florida, Kansas, Massachusetts, North Dakota, North Carolina, Oklahoma, Oregon, Texas, and Wisconsin.

Death Threats, Home Picketing, and Stalking Still Terrorize Many Physicians and Clinic Workers

While overall clinic violence decreased in 1995, *the types of violence that target physicians and clinic staff at their homes and offices remained at high levels*. Almost *one in five clinics (17.1%) reported death threats* in 1995; *one in five (20.3%) reported home picketing;* and *one in ten (10.6%) said clinic staff had been stalked*. While these reports of death threats, stalking, and home picketing also represented declines since 1994, this violence still posed a significant threat to abortion providers. (See Chart 3).

Relatively few clinics in 1995 reported blockades (6.5%), invasions (5.8%), or chemical attacks (1%). Bomb threats were reported by 14.5% of clinics.

Vandalism was the most highly reported type of violence, with almost one-fourth (24.8%) of clinics reporting that their facilities had been vandalized. Acts of vandalism included glue in door locks (5.2%), nails in clinic driveways or parking lots (2.9%), motor oil in parking lot (1.9%), paint on building (8.1%), and broken windows (9.4%). Other forms of vandalism included destruction of property and landscaping, disposal of trash on clinic property, placement of locks on clinic doors and gates, and tampering with clinic utilities such as electricity and water.

Facing the mobilization of abortion rights activists at clinics, protest injunctions, and buffer zones, anti-abortion extremists largely have abandoned clinic blockade and clinic invasion strategies in favor of more threatening strategies aimed at par-

Chart 5. Clinic Reports of Blockades, Invasions, Death Threats, and Stalking , 1993-1995

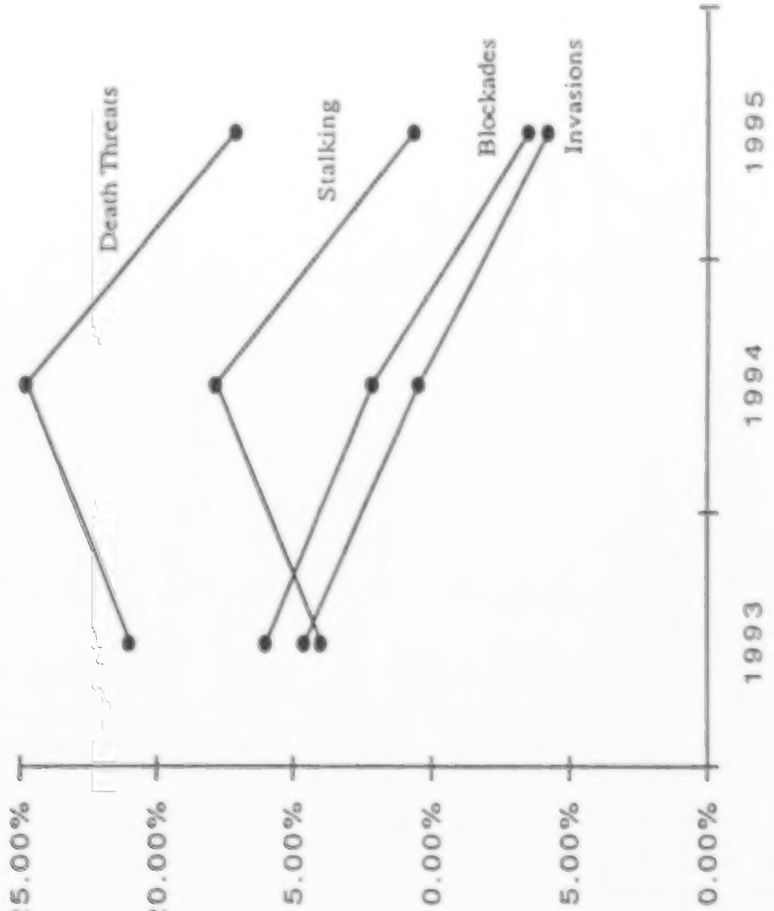
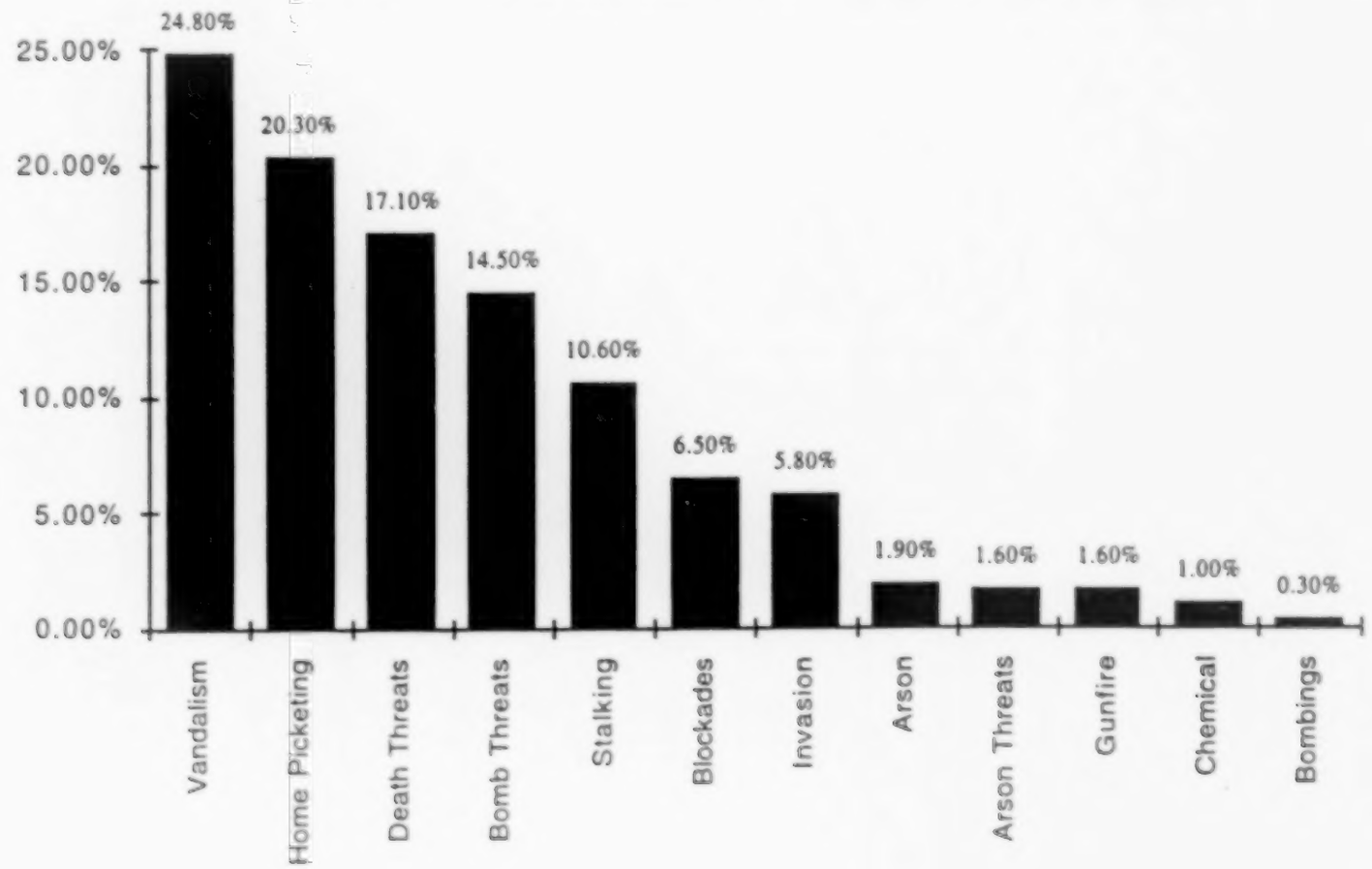


Chart 3. Violence By Type During First Seven Months of 1995



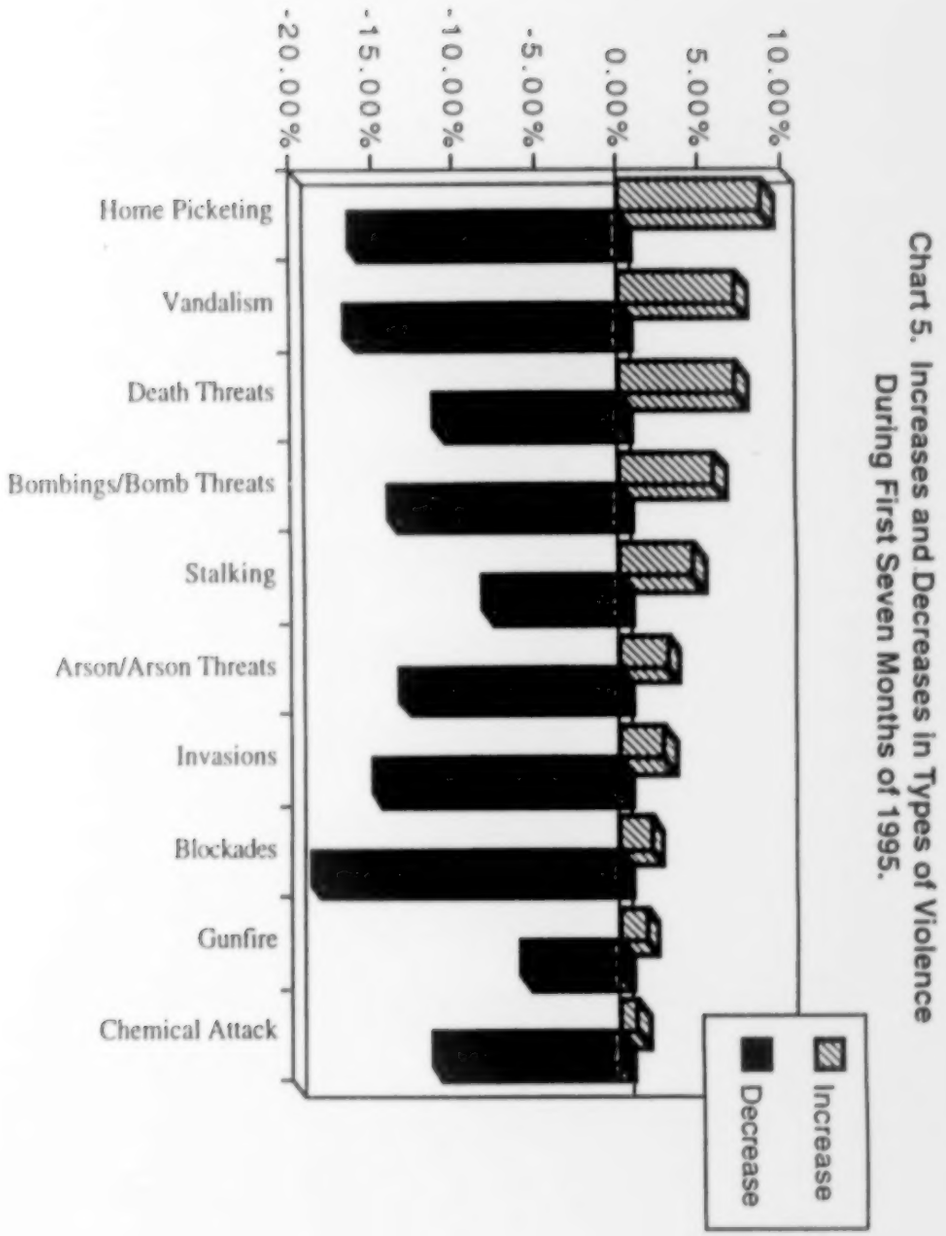


Chart 5. Increases and Decreases in Types of Violence During First Seven Months of 1995.

ticular physyicians and clinic workers such as death threats, stalking, and home picketing. Chart 5 illustrates the patterns of decline in various types of violence over the past three years, based on our annual surveys.

For the first time, in every category of violence, more clinics in 1995 reported decreases than increases in incidence. Chart 5 reveals reported increases and decreases in specific types of violence in 1995, compared with 1994. Significantly, however, *the smallest net decreases occurred in death threats and stalking*.

One In Ten Clinics Lose Staff As A Result of Anti-Abortion Violence

Clinics continued to lose staff as a result of anti-abortion violence. *In 1995, 9% of clinics reported that staff members had quit as a result of anti-abortion violence and harassment*. A similar number of clinics reported violence-related resignations in 1994. Both 1994 and 1995 levels of staff resignations represented a major decline from 1993, when one-fourth of clinics said they had lost staff members because of fears of violence.

Clinics which were the most heavily besieged by violence were the most likely to lose staff members. Of the clinics experiencing high levels of violence, 13.6% said staff members had resigned, compared with 9.3% fo clinics reporting moderate violence and 7.3% of clinics reporting no violence.

The murder of two clinic workers and shooting of five other people in Brookline, Massachusetts on December 30, 1994 sent shockwaves through the nation. The attacks especially intensified fear among staff members at clinics around the country. *Over sixty percent (60.7%) of clinics which reported staff losses as a result of violence in 1995 said those staff members had quit as a direct result of the Brookline murders*.

One In Five Clinics Reported FACE Violations

One in five clinics (20%) surveyed said they had reported violations of the Freedom of Access to Clinic Entrances Act (FACE) to federal law enforcement officials — an increase in reports from 16.5% in 1994.

Enacted in May of 1994, FACE makes anti-abortion violence a federal crime. The Act provides federal jurisdiction and enacts specific federal penalties, including felony offenses and civil fines, for those convicted of using force, the threat of force, or physical obstruction against patients, health care workers, and clinics.

The federal government's enforcement of FACE increased substantially in 1995. According to the Department of Justice, the first full year of FACE implementation resulted in 133 criminal civil rights investigations, 15 indictments, and 15 convictions. Nine FACE civil actions were brought by the federal government. In 1995, the U.S. Supreme Court also rejected the American Life League's challenge to the constitutionality of FACE.

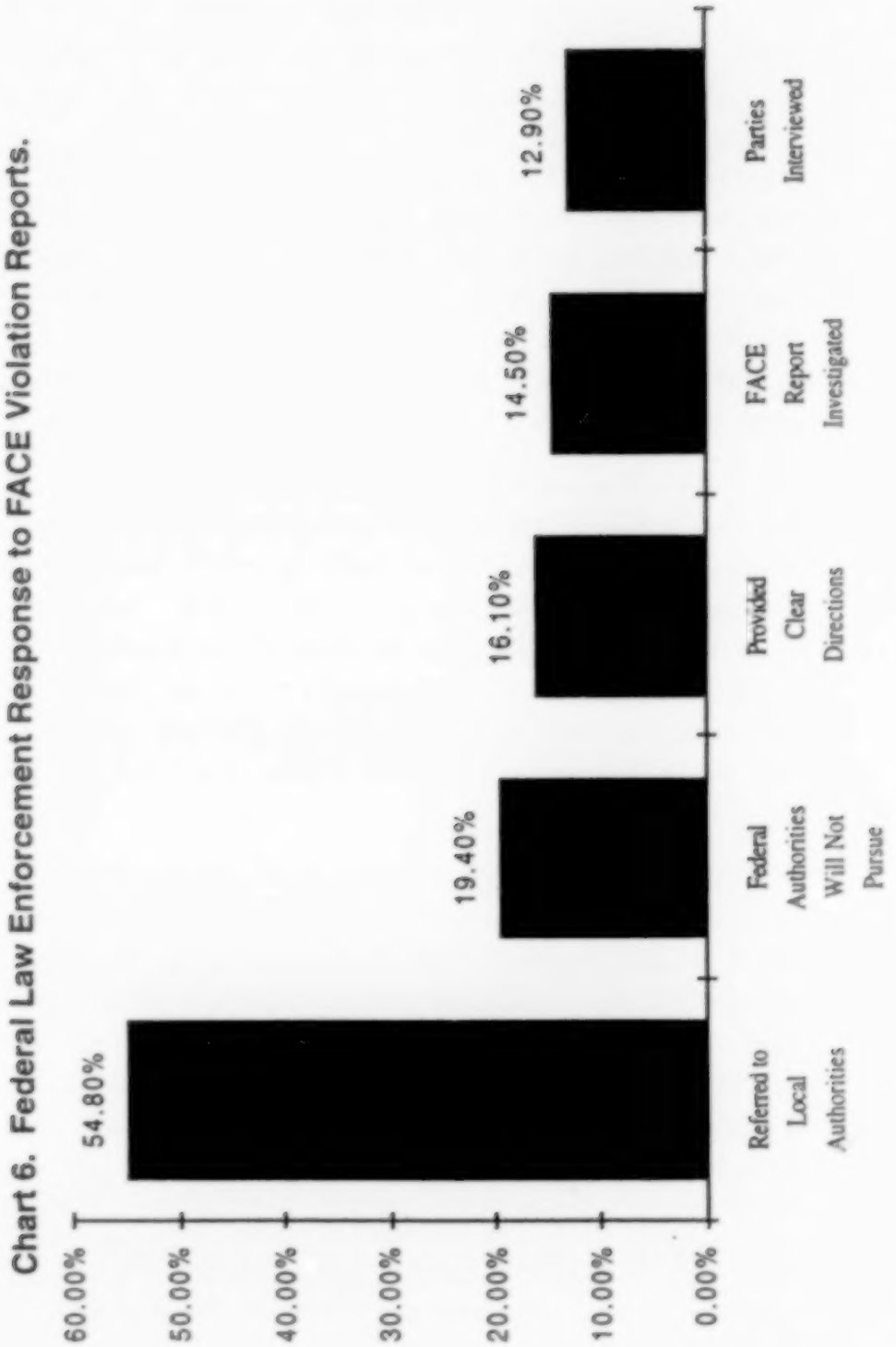
Key events in FACE enforcement in 1995 included the conviction of Paul Hill for the 1994 murders of Dr. John Bayard Britton and clinic escort James Barrett and shooting of June Barrett. A possible murder of a physician was averted in August of 1995 when the FBI arrested Robert Cook, an anti-abortion extremist, who allegedly robbed an armed car of $260,000 and planned to use the money to "fund a war against abortion." Cook was arrested just days before he planned to start his war by killing an abortion doctor. Cook was convicted of FACE violations as well as larceny, money laundering, and solicitation.

While FACE enforcement steadily improved in 1995, federal officials were still reluctant to use FACE to address many instances of clinic violence. *The 1995 survey found that the majority of FACE reports that clinics made to federal officials were referred to local law enforcement officials.* Of the 62 clinics making FACE reports, 54.8% were told their claims should be handled under local and state laws. *Almost one-fifth (19.4%) of clinics reporting FACE violations said that they were advised that federal authorities would not prosecute.* Only 16.1% of clinics that reported FACE violations said that law enforcement officers provided clear directions for initiating formal FACE complaints. *Only 14.5% of clinics reported that their FACE reports were formally investigated* and just 12.9% said involved parties were officially interviewed. (See Chart 6.)

Very few clinics reporting FACE violations said their reports had resulted in civil or criminal action under the federal law. Reported FACE violations resulted in FACE criminal proceedings for only 8.1% of clinics. Only 4.8% of clinics that reported FACE violations pursued FACE civil action. U.S. attorneys intitiated FACE complaints for 8.1% (25) of the clinics. Of the clinics surveyed, one won a FACE civil suite, three won FACE injunctions, and one clinic won FACE criminal charges.

For-profit clinics were more likely than non-profit clinics or private doctors offices to report FACE violations. In 1995, 43.5% of FACE violations were reported by for-profit clinics, with non-profit clinics accounting for 30.6% and private doctors offices accounting for 24.2% of FACE reports. This pattern represents a shift from the 1994 data which showed far more non-profit clinics than for-profit or private doctors office facilities reporting violations of FACE.

The majority (60.6%) of clinics said that they had been informed by federal authorities of the appropriate FACE contact in the U.S. Attorneys office in their districts.



Law Enforcement Response Improved in 1995

Local, state, and federal law enforcement officials won higher marks from clinics for their responses to anti-abortion violence in the 1995 than in 1994. Local law enforcement response was ranked as "excellent" by 43.9% of clinics in 1995, with 32.3% calling local law enforcement response "good," and 8.7% of clinics reporting "poor" responses. In 1994, 30.3% of clinics reported that local law enforcement response was "excellent;" 35.4% said local response was "good;" and 11.5% of clinics experienced local response as "poor."

Federal law enforcement received significantly higher ratings from clinics in 1995 than in 1994. Of the clinics, 20.3% reported "excellent" federal response in 1995, with 31% of clinics saying federal response was "good" and 12.9% stating they had experienced a "poor" response from federal officials. In 1994, only 10.5% of clinics had reported an "excellent" response from federal law enforcement, 21.3% said the federal response was "good" and 8% characterized federal response as "poor."

Clinics ranked state law enforcement response lower. State law enforcement response was identified by 15.5% of clinics as excellent, 24.5% as good, and 8.1% as poor. These results, however, showed significant improvement in state response since 1994, when 7.3% of clincis reported state response as excellent, 15.9% as good, and 8.9% as poor.

The 1995 survey results also suggested that clinics were interacting more with law enforcement officials at all levels than in the past. In 1995, only 15% of clinics responded "don't know" to questions about local law enforcement response, compared with 22.9% in 1994. Slightly over one-half of clinics (51.9%) were unable to describe state law enforcement response to clinic violence, but this still represented improvement since 1994 when 67.8% could not characterize state enforcement efforts. Similarly, 35.8% of clinics in 1995 responded

"don't know" when asked to rank federal law enforcement response, compared with 60.2% in 1994.

Another measure found a significant number of clinics in 1995 interacted with federal officials. Over two-thirds (68.1%) of clinics reported that they had been contacted by U.S. marshals about clinic violence.

Most clinics reported little change in local, state, or federal response to clinic violence when asked to compare 1995 levels of response with their experiences in 1994. The plurality of clinics said local (46.1%), state (40.6%), and federal (42.3%) response "remained the same" as in the previous year. Very few clinics reported that law enforcement response at any level had declined.

Clinics reported the most improvement in local law enforcement response, followed by federal response. Of the clinics, 34.5% said local law enforcement response had "improved," while 26.5% noted improvements in response from federal law enforcement. 17.7% of clinics said state law enforcement response had "improved."

Levels of Violence Correlate with Law Enforcement Response

A clear relationship between clinic violence and law enforcement response emerged from the 1995 survey data. Only 11% of clinics reporting excellent local law enforcement experienced high levels of violence, compared with 33.3% of clinics who reported poor law enforcement response.

A similar pattern appeared in relation to state law enforcement response. Of those clinics experiencing a poor state law enforcement response, 28% report high levels of clinic violence; only 14.6% of clinics reporting excellent state law enforcement response experienced high levels of violence.

Death threats, in particular, are consistently related to local, state, and federal law enforcement response. Better law enforcement response corresponded with fewer death threats. Bombings/bomb threats, vandalism, and death threats had statistically significant relationships with federal law enforcement response. Statistically significant relationships also were found between local law enforcement response and death threats, stalking, vandalism, blockades, and invasions. Stalking and death threats were the only two types of violence that correlated with state law enforcement response at a significant level.

Another indication of law enforcement response was the number of clinics that reported arrests and whether charges were filed in these cases. *Only 13.8% (43) of clinics reported arrests as a result of violence at clinics.* Of the clinics, 11.6% (36) reported misdemeanor arrests or arrests for violation of local ordinances; 1.6% (5) reported felony arrests; and .6% (2) reported both misdemeanor/felony.

Arrests were clearly related to the levels of violence experienced by clinics. Clinics that experienced higher levels of violence indicated more arrests regardless of whether the violent acts took place at or away from clinics. Over one-third (36.3%) of the clinics that experienced a high level of violence reported arrests for felonies and misdemeanors committed at clinics. Only 14.7% of clinics affected by moderate levels of violence reported arrests for anti-abortion activities at the clinics. Of the clinics that reported high levels of violence, 11.4% noted either felony or misdemeanor arrests related to violence that took place away from clinics. Only 3.9% of clinics that reported moderate levels of violence also indicated arrests for conduct away from clinics.

Approximately one-third of clinics that reported misdemeanor and local ordinance arrests also indicated that charges were filed

as a result of the arrests. Of the 36 clinics reporting misdemeanor/local ordinance arrests related to anti-abortion violence at clinics, 33.3% said charges were filed and another 5.6% said charges were filed in some cases, but not others. Of the 8 clinics that reported misdemeanor/local ordinance arrests related to anti-abortion violence targeted at physicians and staff away from clinics, 37.5% said charges were filed. All of the clinics that reported felony arrests said charges were filed. One of the two clinics that reported both felony and misdemeanor arrests related to violence at clinics said charges were filed.

Less Than Half of Clinics Won Legal Protections

Over one-third (35.5%) of clinics are currently protected under civil injunctions or buffer zones.

In 1995, 15.2% of clinics turned to the courts to seek relief from clinic violence. Of the clinics, 3.2% sought temporary injunctions, 5.8% permanent injunctions, and 4.2% restraining orders.

Only 46.8% of clinics who sought legal remedies actually obtained the desired protection. Clinics in 1995 were less successful than in 1994 in winning restraining orders and temporary injunctions to protect themselves from clinic violence. In 1995, 46.2% of the clinics requesting temporary restraining orders against anti-abortion extremists won restraining orders, compared with 68.8% in 1994. Fifty percent of clinics who sought temporary injunctions in 1995 won those injunctions, in comparison to 62.5% of clinics in 1994.

On the other hand, *clinics in 1995 were extremely successful in obtaining permanent injunctions.* All but 5 of the 18 clinics that sought permanent injunctions won those injunctions, for a total of 72.2%. In 1994, only 27.8% of clinics seeking permanent injunctions won that legal remedy.

CONCLUSIONS

Levels of clinic violence in 1995 declined substantially. Fewer clinics reported incidents of death threats, stalking, home picketing, vandalism, chemical attacks, blockades, arson and arson threats, invasions and gun fire. In every category of violence, more clinics reported decreases than increases.

Violence directed at individual physicians and clinic staff, however, continues at unacceptably high levels. Almost one-fifth (17.1%) of clinics reported death threats in 1995. A similar proportion (20.3%) of clinics indicated that the homes of clinic staff and physicians had been picketed. One in ten (10.6%) clinics said staff and physicians had been stalked by anti-abortion extremists. Of all the types of violence, death threats had the smallest net decrease in 1995.

And these types of violence have taken their toll on clinic staff. One in ten clinics still report that staff members have quit as a result of anti-abortion violence. The murders of clinic staff in Brookline Massachusetts by John Salvi accounted for almost two-thirds of these resignations.

Decreases in clinic violence were tied directly to law enforcement response. The survey found statistically significant correlations between levels of violence and local, state, and federal law enforcement response. The level of death threats appeared to be particularly sensitive to law enforcement activities. Death threats were the only types of violence in which a statistically significant relationship was indicated with local, state, *and* federal law enforcement activities.

Clinics consistently reported that law enforcement at the local, state, and federal levels had improved. These improvements without question have helped diminish anti-abortion violence overall. However, clinics also reported that implementation of the Freedom of Access to Clinic Entrances Act has

not been as vigorous as it could be. Although one in five clinics reported FACE violations, very few of these reports resulted in criminal or civil action. Enforcement of FACE and the increased involvement of federal and state as well as local officials clearly is necessary to end the serious violence which continues to plague a significant proportion of clinics in the United States.

APPENDIX A
Clinics Responding to Survey State-by-State

Alabama	7
Arizona	10
Arkansas	3
California	41
Colorado	5
Connecticut	10
Florida	24
Georgia	4
Illinois	5
Indiana	5
Iowa	5
Kansas	5
Kentucky	1
Louisiana	4
Maine	2
Maryland	9
Massachusetts	5
Michigan	16
Minnesota	5
Mississippi	1
Missouri	2
Montana	3
Nebraska	1
Nevada	4
New Hampshire	3
New Jersey	8
New Mexico	2
New York	22
North Carolina	10
North Dakota	1

Ohio	16
Oklahoma	2
Oregon	5
Pennsylvania	7
Rhode Island	2
South Carolina	2
South Dakota	1
Tennessee	6
Texas	17
Utah	2
Vermont	5
Virginia	5
Washington	9
Wisconsin	5
American Samoa	1
	310

APPENDIX B
State-by-State Analysis For Twelve States With Highest Levels of Anti-abortion Violence During the First Seven Months of 1995

Alabama

Four of the seven Alabama clinics received death threats. Three clinics received bomb threats. One clinic received an arson threat. Three clinics were vandalized. One clinic reported staff members had been picketed at home. Three clinics reported stalking. One clinic said staff had quit as a result of anti-abortion violence. Four clinic reported FACE violations. One clinic is protected by an injunction or buffer zone.

California

Only four out of forty-one clinics in California reported blockades. Three clinics faced invasions. Nine clinics received bomb threats. Two clinics experienced arson. Twelve clinics experienced vandalism. Four clinics reported home picketing. Four clinics reported death threats. One clinic reported gunfire. Two clinics reported violence-related staff resignations. Six clinics informed authorities of FACE violations. Six clinics said they were protected by buffer zones or injunctions.

Colorado

One of the five clinics in Colorado was invaded during the first seven months of 1995. A bomb threat was received by one clinic. Two clinics were vandalized. One clinic said staff experienced home picketing. Two clinics reported staff members had been stalked. Two clinics reported death threats. Two clinics lost staff as a result of violence. Two clinics told federal authorities of FACE violations. One clinic reported a suit for civil damages had been filed under FACE. Two clinics said they had buffer zones or injunctions.

Florida

Only one of twenty-four clinics in Florida reported blockades. One clinic received a bomb threat. One clinic was set on fire. Four clinics reported vandalism. Three clinics reported home picketing. Two clinics reported that staff members had been stalked. Four clinics received detah threats. One clinic reported staff resignations as a result of clinic violence. Four clinics reported FACE violations. Buffer zones or injunctions are in place at nine clinics.

Kansas

One of the five Kansas clinics experienced arson. Two clinics were vandalized. Two clinics said staff were picketed at home. Two clinics reported stalking. Three clinics received death threats. One clinic informed federal authorities of FACE violations. One clinic reported a FACE civil suit had been filed. One clinic reported FACE criminal charges had been filed. One clinic has a buffer zone or injunction.

Massachusetts

Three of the five Massachusetts clinics reported bomb threats. One clinic reported home picketing. Staff members at two clinics were stalked. Death threats were received by three clinics. One clinic reported gunfire. One clinic reported staff members had quit as a result of anti-abortion violence. One clinic reported FACE violations. Five clinics are protected under an injunction.

North Carolina

Three out of the ten North Carolina clinics experienced blockades in the first seven months of 1995. Two received bomb threats. Four clinics were vandalized. Three clinics reported staff members had been picketed at home. Two clinics had staff members who had been stalked. Four clinics reported death threats. Four clinics told federal authorities of FACE violations. Two clinics reported FACE criminal

charges had been filed. Two clinics are protected by buffer zones or injunctions.

North Dakota

The lone North Dakota clinic reported home picketing, death threats, and stalking. The clinic also reported FACE violations to federal officials. A buffer zone or injunction was in place at the clinic.

Oklahoma

One of the two clinics from Oklahoma in the sample was hit by a blockade. One clinic was vandalized. One clinic said staff were picketed at home. Staff members of one clinic were stalked.

Oregon

One of the five Oregon clinics reported a blockade. Two clinics were invaded. One clinic experienced vandalism. All five clinics reported picketing at the homes of staff members and physicians. One clinic reported death threats. One clinic reported staff had quit because of anti-abortion violence. FACE violations were reported at one clinic. One clinic reported FACE criminal charges had been filed. Four clinics have buffer zones or injunctions.

Texas

Only two out of seventeen Texas clinics experienced blockades. Four clinics reported invasions. Three received bomb threats. Four clinics were vandalized. Five clinics reported home picketing. Death threats were received by two clinics. One clinic reported gunfire. Two clinics said staff quit as a result of clinic violence. Three clinics reported FACE violations. Eight clinics are protected by buffer zones or injunctions.

Wisconsin

One clinic in Wisconsin was invaded, and one received a bomb threat. Four of the five clinics were vandalized. Three clinics reported home picketing. Three clinics said staff members had been stalked. Three clinics reported death threats. FACE violations were reported at two clinics. One clinic reported FACE criminal charges have been filed. Four clinics have buffer zones or injunctions.